UCSF Helen Diller Family Comprehensive Cancer Center
Cancer Risk Program

1600 Divisadero Street, Box 1714, San Francisco, CA 94143

1. Basic Information

Name: | Address: | City/St/Zip: | Country: | Phone:

Middle | *Maiden* | Male *Gender* | *Date of Birth* | *Your Place of Birth*

Home | *Work* | *Cell* | *fax* | *Email* | *SSN*

Education Completed:
- ○ None
- ○ Some College (1-3 yrs)
- ○ Grade School
- ○ College Degree
- ○ High School Degree
- ○ Graduate School

Ethnicity:
- ☐ African-American
- ☐ Caucasian
- ☐ American Indian/Native Alaskan
- ☐ Hispanic
- ☐ Asian
- ☐ Native Hawaiian/Pacific Islander

Current Status:
- ○ Never Married
- ○ Widowed
- ○ Married
- ○ Partnered
- ○ Divorced
- ○ Other

Detailed Ethnicity (Please enter the countries where your grandparents came from.)

Pat Grandfather | Pat Grandmother | Mat Grandfather | Mat Grandmother

Current or Former Occupation:

Religion (if any):

Current Employment Status:
- ○ Full-Time
- ○ Part-Time
- ○ Unemployed
- ○ Disabled
- ○ Retired

Total family income for last year:
- ○ Less than $10,000
- ○ $10,000-$19,999
- ○ $20,000-$29,999
- ○ $30,000-$39,999
- ○ $40,000-$49,999
- ○ More than $50,000

Medical Insurance Carrier: | Type: | Member #:

Do you wish to cover your visits through your insurance? ○ Yes ○ No

Have you received authorization for your visit? ○ Yes ○ No

Primary Care MD

Name: *First* *Last* | Address: | City | State | Zip Code

Phone: | Fax: | Email:

Specialty Care MD Specialty :

Name: *First* *Last* | Address: | City | State | Zip Code

Phone: | Fax: | Email:

Do you have any particular concerns you would like to discuss with a genetic counselor?

2. Your Vital Statistics and Birth History

What was your BIRTH weight (lbs)? ____ How TALL are you (ft in)? ____ What is your CURRENT WEIGHT(lbs)? ____

What is the MOST you have ever weighed, excluding pregnancy (lbs)? ____

What did you weigh (lbs) when were you when you were 18 YEARS old? If you cannot remember, what was your dress size?

Was your mother a SMOKER when pregnant with you? ○ Yes ○ No ○ Unknown

Did your mother take DES (diethylstilboestrol, a drug to prevent miscarriage) when pregnant with you? ○ Yes ○ No ○ Unknown

3. Your Cancer History

Have you ever been diagnosed with cancer? ○ Yes ○ No

If YES, please complete the information below:

TYPE OF SURGERY E.G. LUMPECTOMY, QUADRANTECTOMY, MASTECTOMY, LAPAROTOMY, HYSTERECTOMY, COLECTOMY etc

SITE	TYPE OF CANCER	AGE	YEAR OF DIAGNOSIS	TYPE OF SURGERY	HOSPITAL	CITY	STATE

4. Your Past Medical History

Has a doctor ever told you that you have any of the following medical problems?

Hypertension	○ Yes ○ No	Gallstones	○ Yes ○ No
Diabetes	○ Yes ○ No	Peptic ulcer	○ Yes ○ No
Emphysema	○ Yes ○ No	Arthritis	○ Yes ○ No
Chronic bronchitis	○ Yes ○ No	Diverticulitis or diverticulosis	○ Yes ○ No
Coronary heart disease	○ Yes ○ No	High levels of cholesterol	○ Yes ○ No
Stroke of transient ischemic attack (TIA)	○ Yes ○ No	Hyperthyroidism	○ Yes ○ No
Chronic pancreatitis	○ Yes ○ No	Hypothyroidism	○ Yes ○ No
Hepatitis	○ Yes ○ No	Auto-immune illness	○ Yes ○ No
Hemorrhoids	○ Yes ○ No	Immune deficiency syndrome	○ Yes ○ No
Kidney disease	○ Yes ○ No	History of depression	○ Yes ○ No
		Other psychological conditions	○ Yes ○ No

4. Your Past Medical History continued

Please list any medical conditions (eg diabetes, high blood pressure, asthma etc) that you take/have taken medications to treat either currently or in the past. Please give the drug name, the dose and the length of time you have taken the drug regularly

NAME OF MEDICAL CONDITION	AGE DIAGNOSIS	WHAT DRUG TREATMENT, IF ANY?	DOSE mg/day	TIME ON THIS DRUG (years)

Have you had any surgeries, injuries, traumas or broken bones? ○ Yes ○ No

SURGERY OR INJURY	REASON FOR THE SURGERY	YEAR

Have you ever had one or more of the following gastro-intestinal examinations listed below:

Have you ever had a sigmoidoscopy? ○ Yes ○ No

Have you ever had a colonoscopy? ○ Yes ○ No

If YES to either, please fill in information below:

COLON or SIGMOID EXAM?	Number of POLYPS	DATE	HOSPITAL	CITY	STATE

Have you ever had a Barium Enema? ○ Yes ○ No If YES, give a date of most recent examination

Have you ever had an upper GI endoscopy? ○ Yes ○ No If YES, what was the result?

5. Skin Cancer Risks

What is your SKIN color? ○ Very Fair ○ Moderately Fair ○ Medium ○ Dark or Olive

What is your NATURAL hair color? ○ Blond ○ Red ○ Light Brown ○ Dark Brown or Black

What is your EYE color? ○ Blue ○ Green,Grey or Golden ○ Hazel ○ Brown or Black

How many times did you suffer from BLISTERING SUN BURN before the age of 20y? ☐

Have you ever used a UV tanning bed regulary? ○ Yes ○ No

If YES, time using a tanning bed if used regularly ○ 1/week for < 1 year ○ 1/week for 5 -10 years ○ 1/week for 1 - 5 years ○ 1/week for 10 - 20 years

How many MOLES do you have? ○ 10 or fewer ○ >10 ○ >20 ○ >50 ○ >100

Have you ever had any SKIN LESIONS, lumps or cysts removed? eg. basal cell carcinomas, squamous cell carcinomas, melanomas, lipomas, atypical moles, solar keratoses etc. ○ **Yes** ○ **No**

TYPE OF SKIN LESION	AGE	DATE AND HOSPTAL WHERE REMOVED

6. Life Style and Dietary History

Tobacco

Do you SMOKE? ○ Yes ○ No ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing Tobacco ☐ Snuff

If CIGARETTES, how many do you smoke a day? ☐

Have you EVER smoked? ○ Yes ○ No ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing Tobacco ☐ Snuff

Total # years smoked ☐

If YES, at what age did you START smoking? ☐ At what age did you STOP smoking? ☐

How many cigarettes per day? ☐

If you are a life-long NON SMOKER, have you ever lived with a smoker? ○ Yes ○ No

If YES, for how many years? ☐

6. Life Style and Dietary History continued

Alcohol

Do you drink alcohol? ○ Yes ○ No

If YES, how many units per week? 1 unit = 1 glass of wine, 1 bottle of beer or 1 ounce of liquor

Have you drunk more than this in the past? ○ Yes ○ No

If **YES**, how many units per week? 1 unit = 1 glass of wine, 1 bottle of beer or 1 ounce of liquor

How many years at this average?

Diet and Exercise

How would you rate your physical activity?
strenuous exercise four or more days/week 5 — 4 — exercise is inconsistent but more than 10 times/month 3 — 2 — very little exercise 1

How often do you eat red meat?
never eat red meat 1 — 2 — 3 — 2 X per week or less — 4 — more than 2 X per week 5

How often do you eat poultry?
never eat poultry 1 — 2 — 3 — 2 X per week or less — 4 — more than 2 X per week 5

How would you classify the amount of fiber in your diet?
high fiber 5 — 4 — medium fiber 3 — 2 — low fiber 1

How would you classify the amount of fat in your diet?
high in fat 5 — 4 — medium fat 3 — 2 — low fat 1

Do you drink coffee regularly? ○ Yes ○ No

How old were you when you started drinking coffee regularly?

Do you usually drink caffeinated or decaffeinated coffee? ○ caffeinated ○ decaffeinated

How many cups of coffee do you usually drink each day?

Support Network

Are you using any of the following psychological/emotional support groups?

- ☐ Family and friends
- ☐ Professional individual counseling
- ☐ Support group

7. FOR WOMEN ONLY - GYNECOLOGICAL AND BREAST HEALTH QUESTIONS:

Menarche

At what AGE did your periods start? [ ]

Are/were your periods REGULAR? ◯ Yes ◯ No

Birth Control Pills

Have you ever taken birth control pills ? ◯ Yes ◯ No

If YES, please list below one line for each continuous use of each type of pill:

NAME OF PILL (IF KNOWN)	DATE STARTED	DATE STOPPED	REASON FOR STOPPING PILL

Pregnancies

Have you ever been pregnant? ☐ YES ☐ NO

Please write the YEAR of each of your pregnancies and check the box for each pregnancy outcome.
If TWINS please write 'T' next to the YEAR of pregnancy

YEAR	MISCARRIAGE?	TERMINATION?	STILL BIRTH?	LIVE BIRTH?	LENGTH PREGNANCY weeks	BREAST FED?	TIME BREAST FED months

Infertility Drugs

Did you ever take any infertility drug(s)? ◯ Yes ◯ No

INFERTILITY DRUG	YEAR TAKEN	MONTHS TAKEN OR CYCLES TAKEN

7. FOR WOMEN ONLY - GYNECOLOGICAL AND BREAST HEALTH continued:

Have you ever taken a drug while pregnant to prevent miscarriage? ○ Yes ○ No If YES, name the drug taken

Menopause

Have you started your menopause? ○ Yes ○ No Date of your last period

Was your menopause natural? ○ Yes ○ No

If your menopause was NOT natural please explain what happened in the box below:

Hormone Replacement Therapy (estrogen and/or progesterone preparations)

Have you ever had hormone replacement therapy? ○ Yes ○ No

If YES, please list below one line for each continuous use of HRT:

HRT BRAND OR TYPE	DATE TOOK	REASON TAKING FOR HRT	DATE STOPPED HRT	REASON FOR STOPPING HRT

Hysterectomy

Have you ever had a hysterectomy? ○ Yes ○ No If YES, please give the date

Oophorectomy

Have you ever had both ovaries removed? ○ Yes ○ No If YES, please give the date

Have you ever had one ovary removed? ○ Yes ○ No If YES, what was the date of that surgery?

Have you ever had the other ovary removed? ○ Yes ○ No If YES,what was the date of that surgery?

If you still have one or two ovaries, have you ever had screening for ovarian cancer? ○ Yes ○ No

If YES, what test(s) have you had? ☐ NP pelvic exam ☐ MD pelvic exam ☐ vaginal USS ☐ CA125

Date(s) of ovarian screening if any Result

7. FOR WOMEN ONLY - GYNECOLOGICAL AND BREAST HEALTH continued:

Breast Health

Do you examine your own breasts? ○ Yes ○ No How often in the last six (6) months? _____

Have you ever had a mammogram? ○ Yes ○ No

If YES, how often do you normally have mammograms? _____

How old were you when you had your 1st mammogram? _____

How many mammograms have you had? _____

Have you ever seen a physician regarding a breast lump? ○ Yes ○ No If YES, how many times? _____

Breast Biopsy

Have you ever had a breast biopsy done? ○ Yes ○ No

If YES complete below, one line for each biopsy:

DATE	L or R	HOSPITAL	CITY	ST	PATHOLOGY: Fibrocystic Disease	Atypical Hyperplasia	DCIS	LCIS	CANCER	Unknown	OTHER eg, fibroadenoma

Drugs to Prevent Breast Cancer

Have you taken TAMOXIFEN or ANOTHER DRUG to prevent breast cancer or a recurrence of breast cancer? ○ Yes ○ No

TAMOXIFEN or OTHER eg ARIMIDEX	DATE STARTED	REASON STARTED	DATE STOPPED	REASON STOPPED

8. Environmental History

Please list all the places you have lived for three years or longer below. Start with the first place you lived as a child.
If you moved within the same city or town, count this only once.

CITY	STATE	COUNTRY	# YEARS

Please indicate if you have had **REPEATED** contact (i.e. contact everyday for at least three months) with any of the following materials in your work, around the home, in your hobbies or during other activities. NB.inclusion of a substance in this list does NOT mean it is known to increase cancer risk

Substance		Substance		Substance	
Animals excluding pets		**Film developing fluids**		**Pesticides, herbicides**	
Arsenic containing compounds		**Glue**		**Petroleum products** (not gas)	
Asbestos (brake lining, insulation, fire proofing)		**Grain dust**		**Plastics** (eg.vinyl chloride)	
Asphalt		**Iron ore**		**PCB** (electrical transformers)	
Benzene, xylene or other solvents		**Lead compounds** (solder)		**Radiation** (not X rays)	
Beryllium (copper alloy for springs, electrical contacts)		**Metal dust/fumes**		**Talcum powder**	
Cadmium		**Mustard gas**		**Trichloroethylene**	
Chemical fertilizers		**Nickel alloys**		**Hair spray**	
Chromium compounds		**Nitrates or nitrites**		**Insulation material**	
Coal		**Paint or finish remover**		**Uranium**	
Dry cleaning solvents		**Paint products**		**Zinc**	
Dye					

Have you had any other environmental exposure that you believe may affect/have affected your health?

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Medical History of Your Family Part 1: You, Your Spouse, Your Parents and Your Grandparents

Please complete with the **full name and date of birth of each family member**. Please complete age or date of death where it is applicable. Include only your biological relatives and your spouse. Do not include adoptive, foster or step parents. If you do not know the exact date of birth, for example, try and give a reasonable estimate of the year in which they were born.

For each relative, please mark whether or not they have had cancer. For those with a history of cancer please fill the organ and/or the type of cancer where this is known.

For your **female relatives** please indicate whether the person concerned ever had surgery **to remove her ovaries and at what age, if known**.

Relative	First Name	Last Name	Birth Date	Age now	If dead, AGE death +YEAR death	Cancer Yes or No	Age diagnosis	Cancer organ	Age ovaries removed *if ever*
Self						☐ ☐			
My Biological Mother						☐ ☐			
My Biological Father						☐ ☐			
My Mother's Mom						☐ ☐			
My Mother's Dad						☐ ☐			
My Father's Mom						☐ ☐			
My Father's Dad						☐ ☐			
My 1st Spouse						☐ ☐			
My 2nd Spouse						☐ ☐			

Medical History of Your Family Part 2: Your Brothers and Sisters

Please complete with the **full name and date of birth of all your siblings, living and deceased**. Please complete age or date of death where it is applicable. If you do not know the exact date of birth, for example, try and give a reasonable estimate of the year in which they were born.
For each relative, please mark whether or not they have had cancer. For those with a history of cancer please fill the organ and/or the type of cancer where this is known.
For your **sisters,** please indicate whether the person concerned ever had surgery **to remove her ovaries and at what age, if known**.

Sister/Brother	First Name	Last Name	Birth Date	Age now	If dead, AGE death +YEAR death	Cancer Yes or No	Age diagnosis	Cancer organ	Age ovaries removed *if ever*
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			

Medical History of Your Family Part 3: Your Children

Please complete with the **full name and date of birth of each child**. *Please complete age or date of death where it is applicable.*
For each child, please mark whether or not they have had cancer. For those with a history of cancer please fill the organ and/or the type of cancer where this is known.
For your **daughters,** please indicate whether they ever had surgery **to remove their ovaries and at what age.**

Daughter/Son	First Name	Last Name	Birth Date	Age now	If dead, AGE death +YEAR death	Cancer?	Age diagnosis	Cancer organ	Age ovaries removed *if ever*
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			

Medical History of Your Family Part 4: Your Mother's Brothers and Sisters

Please complete with the **full name and date of birth of each family member**. Please complete age or date of death where it is applicable. Include full and half siblings, do not include adopted siblings. If you do not know the exact date of birth, for example, try and give a reasonable estimate of the year in which they were born.

For each relative, please mark whether or not they have had cancer. For those with a history of cancer please fill the organ and/or the type of cancer where this is known.

For your **aunts**, please indicate whether the person concerned ever had surgery **to remove her ovaries and at what age, if known**.

Aunt/Uncle	First Name	Last Name	Birth Date	Age now	If dead, AGE death +YEAR death	Cancer?	Age diagnosis	Cancer organ	Age ovaries removed *if ever*
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			

Medical History of Your Family Part 5: Your Father's Brothers and Sisters

Please complete with the **full name and date of birth of each family member**. Please complete age or date of death where it is applicable. Include full and half siblings, do not include adopted siblings. If you do not know the exact date of birth, for example, try and give a reasonable estimate of the year in which they were born.

For each relative, please mark whether or not they have had cancer. For those with a history of cancer please fill the organ and/or the type of cancer where this is known.

For your **aunts,** please indicate whether the person concerned ever had surgery **to remove her ovaries and at what age, if known**.

Aunt/Uncle	First Name	Last Name	Birth Date	Age now	If dead, AGE death +YEAR death	Cancer?	Age diagnosis	Cancer organ	Age ovaries removed *if ever*
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			

Medical History of Your Family Part 6: ANY OTHER RELATIVES WITH CANCER i.e. nieces, nephews, first or second cousins, great aunt/uncles etc

Please complete with the **full name and date of birth of each family member**. Please complete age or date of death where it is applicable. If you do not know the exact date of birth, for example, try and give a reasonable estimate of the year in which they were born.

For your **female relatives,** please indicate whether the person concerned ever had surgery **to remove her ovaries and at what age, if known**.

Relationship to you NB Maternal or Paternal relative?	THE PARENTS of this person were	FIRST NAME LAST NAME	Birth Date	Age now	If dead, AGE death +YEAR death	Cancer Yes or No	Age diagnosis	Cancer organ	Age ovaries removed *if ever*
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			
						☐ ☐			

PERMISSION FORM

I hereby agree to permit the Cancer Risk Program at the University of California, San Francisco to obtain my medical records,
pathology slides, and tissue blocks from attending physicians and hospitals, in furtherance of the research studies they are conducting.

This signed permission form may also be used in obtaining the records and tissue blocks of close relatives who are deceased and whose medical records and tissue blocks I am authorized by law to release.

This is my personal contribution, freely given, for the furthering of biomedical research and for familial cancer risk status evaluation.
A duplicate copy is as valid as the original.

_____ _____

Signature Date